Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville, GA 30046-6935
(tel) 770.822.8720 • (fax) 770.822.8735

gwinnettcounty

November 02, 2018

ADDENDUM #2
BL117-18
Individual Stop Loss Coverage on an Annual Contract

Q1. Could you also please provide a copy of the current stop loss contract/policy?
A1. Please see attached.

This addendum should be signed in the space provided below and returned with your bid. Failure to do so may result in your bid being deemed non-responsive.

Thank you

Dana Garland, CPPB
Purchasing Associate III

Company Name_____

Authorized Representative_____

ORIGINAL

Amalgamated Life Insurance Company
Excess Loss Insurance Application

Name of Applicant (Correct Legal Name and Affiliated entities)

Gwinnett County Board of Commissioners

Address (Street, City, State, Zip)

75 Langley Drive, Lawrenceville, GA 30046-6935

Name and Address of Third Party Administrator

Aetna – Tampa Services Center, 4630 Woodlands Corporate Blvd , Tampa FL 33614

Covered Persons ☒ Active ☒ COBRA ☒ Disabled ☒ Hospital Confined
☒ Retired (under age 65 and not covered by Medicare)
☐ Retired (over 65 or covered by Medicare) ☒ Not Actively at Work
☒ Temporarily Disabled ☒ On Approved Leave
☒ Receiving Severance Package ☐ Other (specify)_____

Rates (specify tier rates) Composite $42 32 per covered employee/month

Aggregate Excess Loss ☐ Yes ☒ No

1 Benefits to be covered ☐ Medical ☐ Dental ☐ Prescription Drugs ☐ Vision
☐ Short-term Disability Income ☐ Other _____
2 The Monthly Attachment Point(s) per _____ $ _____
3 The Maximum Annual Aggregate reimbursement is $_____
4 Aggregate Payment after any Aggregate Deductible up to the Maximum Aggregate reimbursement
a _____% of covered expenses or
b _____% of the first _____ of covered expenses and _____% thereafter
5 This policy provides Aggregate Extension if the plan becomes fully insured ☐ Yes ☐ No
6 This policy provides Company payment of claims before the end of benefit period (i e Aggregate Accommodation) ☐Yes No☐

Specific Excess Loss ☒ Yes ☐ No

1 Basis ☐ Paid during the experience period (EP)
☐ Incurred during the experience period
☒ Incurred all months prior to and during the EP and paid during the EP and no months after (Paid)
☐ Incurred during the experience period and paid during and ___ months after the EP (___/___)
2 Benefits to be covered ☒ Medical ☐ Dental ☒ Prescription Drugs ☐ Vision
☐ Short term Disability Income ☐ Other _____
3 $325 000 Specific Annual Deductible for each person Aggregating Specific Deductible of $0 with the exception of the following N/A

4 The Maximum Annual and Lifetime Specific reimbursements per person are $ unlimited and unlimited
5 Specific Payment after any Specific Deductible up to the Maximum Lifetime Specific reimbursement
a 100% of covered or
b _____% of the first _____ of covered expenses and _____% thereafter
6 This policy provides payment of claims by Company before applicant pays the claim (i e Specific Advancement) ☒ Yes ☐ No
7 This policy provides Specific Extension if the plan becomes fully insured ☐ Yes ☒ No

Optional Benefits **check all that apply**

- ☒ Advance Funding
- ☐ Specific Extension Benefit for _____ Months
- ☐ Aggregate Accommodation
- ☐ Aggregate Extension Benefit for _____ Months
- ☐ Expenses in Excess of UCR
- ☒ Other No New Laser renewal for January 1 2019
- ☒ Other Maximum Rate Increase of 49% for January 1 2019

The Supplementary Application Information, Excess Loss Disclosure form and supporting information is made part of this Application and is therefore made part of the Policy

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Requested effective From Effective Date January, 1, 2018 Through December 31, 2018

Deposit of $_____ is enclosed to apply to the first payment under the policy, if issued

Signed at	**Date** 1/24/18
Applicant (Correct Legal Name) **Gwinnett County Board of Commissioners**	**Authorized Signature** Charlotte J. Nash **Charlotte J. Nash** **Chairman**
Agency Name **Aon Hewitt**	**Agent's Signature and Stat No** Paul B [illegible] 701

ATTEST: GWINNETT COUNTY, GEORGIA, ESTABLISHED 1818
County Clerk

Approved as to form
Sr Assistant County Attorney

Amalgamated Representative Michael J Schaefer w/c (914) 539-63[illegible]

Home Office
Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, NY 10604
Phone 914-367-5000

Amalgamated Life Insurance Company
Supplementary Application Information

Network(s) (Name Address Contact Name and Phone Number)

Prescription Drug Network (Name Address Contact Name and Phone Number)

Case Manager(s) - Utilization Review Firm(s) (Name Address contact Name and Phone Number)

Other Cost Saving Networks or Vendors (Name(s) Address Contact Name and Phone Number)

Amalgamated Life requires (unless waived in writing by Amalgamated Life) that the following documents be submitted before coverage becomes effective Failure to submit these documents within 90 days of the date the application is signed may result in non issuance of any Excess Loss coverage upon written notice from Amalgamated Life

1) Latest 5500 Form
2) Completed and signed Disclosure Form
3) Binder Check for the first premium
3) Signed Application Form
4) Copy of Summary Plan Description (SPD) and any amendments
5) Copy of any participant eligibility requirements that are not specified in the SPD
6) Copy of signed Business Associate Agreement from the administrator and Case Management Company if any

Amalgamated Life requires a monthly Notification Report that contains both Threshold (when a claimant s cost is 50% of the specific deductible) and Trigger (diagnosis hospitalized etc) claimants as specified in our Disclosure Form Ideally you would submit a monthly computer claims extract and we would process it to produce the Notification Report Will you be submitting the Report or the monthly claim extract (please specify or describe)? We also require annually a census enrollment report (employees spouses children etc) Forms supplied to your prior carrier if any may be adequate

In regard to Plan provisions are there any unusual provisions that we should be aware of? Please specify below
Does your plan limit Out of-Network payment to UCR? ☐ Yes ☐ No (If yes what percentile of UCR is used? _____ %)

The Applicant agrees that Amalgamated Life can contact the TPA Administrator Case Manager or Utilization Review Firm to obtain information about a claim Please check to confirm ☐ Do you wish such requests to be made in writing? ☐ Yes ☐ No

Which of the following claims case management approaches are used for claimants (check which is applicable)

Preadmission Certification	☐ For all claimants	☐ Only for claimants that volunteer	☐ Only for out of-network claimants
Concurrent Review	☐ For all claimants	☐ Only for claimants that volunteer	☐ Only for out of network claimants
Large Case Management	☐ For all claimants	☐ Only for claimants that volunteer	☐ Only for out-of network claimants
Fee Negotiation	☐ For all claimants	☐ Only for claimants that volunteer	☐ Only for out of-network claimants
In Network Channeling	☐ For all claimants		

Are there any requests or special needs you wish Amalgamated Life to address? _____

Amalgamated Life Insurance Company
Underwriting Department, 333 Westchester Avenue, White Plains, NY 10604

Excess Loss Disclosure Form
and Instructions for Completion

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as a part of "health care operations" The Company shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation

The Company will rely upon the information provided on the attached disclosure form which will become part of the Application for excess loss coverage The purpose of the form is to allow the Company to take underwriting action on all known risks in the categories listed below It is the Plan Sponsor s responsibility either directly or through their designated representative to accurately report all claims known as of the date of this disclosure by making a thorough review of all applicable records Such records shall include but not be limited to historical claims reports including pending claims disability records current information from administrators insurers utilization management companies managed care companies and any Agent/Broker of the Plan Sponsor In exchange the Company will accept the liability for any truly unknown risks The attached disclosure form must be completed and signed by the appropriate parties no more than thirty (30) business days prior to the proposed Effective Date of excess loss coverage contain data that is within 30-45 days from the date of signature and be received by the Company within ten (10) business days from the latest date of signature

Upon receipt of the completed and adequate disclosure the Company will assess all data new and previously reported and will inform the producer in writing within (30) business days of any changes to the rates factors terms of coverage or need for additional data The Company reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process

List on the Disclosure Form all individual risks known to

1 Be currently disabled confined to a Medical Facility have requested a transfer to a rehabilitation facility or have been precertified within the last three (3) months
2 Have received medical services during the current plan year the cost of which exceeds the lesser of 50% of the lowest Specific Retention Amount applied for or $25 000 and for which bills have been received by the Claims Administrator and entered into their Claims System
3 Have been identified as a candidate for Case Management or as having the potential to exceed during the policy period the lesser of 50% of the lowest Specific Retention Amount applied for or $50 000
4 Have been identified as a potential transplant recipient or are actually awaiting a transplant
5 Have been identified as a potential high risk pregnancy or multiple births
6 Be hospitalized beyond 10 days ICU for over a week or SNF confined for over 30 days
7 Be receiving Home Uterine Monitoring/Terbutaline Infusion Therapy IV/Infusion Therapy (i e antibiotics TPN chemotherapy narcotics enteral etc) or 30 or more days of Home Health Care
8 Have been diagnosed during the current plan year with a condition represented by any of the ICD-10-CM codes contained in the attached list Using the attached list if a patient has multiple diagnoses each diagnosis must be disclosed
9 Be in unresolved litigation subrogation or pending Worker s Comp approval
10 Known to have unpaid pending claims greater than $10 000 (list the amount pending)
11 Have gone on COBRA because of a major illness or inability to work

If aggregate coverage is purchased

1 Provide a list of all paid claims month by month for the latest 24-months or a claims triangle
2 From the data used to obtain the aggregate coverage
   a Has there been an increasing inventory of unpaid claims in the most current known three months of data?
   b Has there been an increase in paid claims in the most current known three months of data?

Excess Loss Disclosure Form

Risk Identifier	DOB	Sex	EE, Sp or Ch	(A)ctive, (C)OBRA, (R)etiree, or (T)ermed (L)OA (M)edical leave	Term Date	Diagnosis	Most Recent Date of Service	Expenses Incurred this Plan Year
			Please refer to		disclosure information that			
				Was provided with	the bid on 11/03/17			

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic risks in accordance with the requirements of this form and that it is the result of a diligent search in accordance with the requirements and that the data is the most current available data and includes claims currently in case management **In support of the list, submit the latest pre-certification report, pended claims report, trigger diagnosis report and updated large loss report with case management notes If there are no risks to report that meet the disclosure criteria above please check this box** ☐

If the plan annual or lifetime maximum benefit provision has been amended after 2009 or will be during the next 12 months, disclose all claimants that exceeded the prior maximum(s) that may be reinstated or are currently participants in your plan If none or not applicable, please check this box ☐

If you have purchased Aggregate Excess Loss coverage please attach a list of paid claims month by month for the latest 24 months If the coverage excludes prescription drugs etc the list should include both claims and claims subject to excess loss A triangle or lag report of paid claims is preferred

If one of the signors below fails to disclose any individual or aggregate risk (if aggregate coverage is purchased) known to require disclosure either intentionally or because a thorough review of all records was not conducted then the Company will have no liability for claims on the risk not disclosed

Plan Sponsor		Claims Administrator		Agent/Broker	Aon Hewitt
Signature	Charlotte J. Nash	Signature		Signature	Paul B. Mabee
Name	Charlotte J Nash	Name		Name	Paul B. Mabee
Title	Chairman	Title		Title	Senior Consultant
Date	1/24/18	Date		Date	1/11/18

Approved as to form
Sr Assistant County Attorney

Attest
County Clerk

GEORGIA • ESTABLISHED 1818 • GWINNETT COUNTY

ALSLDF-11(Rev 1)

Modified Self Insurance Institute of American (SIIA) Endorsed – September 2005

Large Claim Listing

GWINNETT COUNTY BOARD OF COMMISSIONERS
Effective 01/01/2017

Contractholder Number 737528
Group Number 737528

This report is designed to meet your need for data in evaluating your benefit plan We have removed individual member identifiers (e g name ID number etc) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations
Amounts below reflect Medical and RX costs

Total Group

Claimants with over $100 000 in claims for 01/01/2017 09/20/2017

Claimant	Amount	ICD 10 Code Description	Relationship	Structure
Claimant 1	$ 460 416	Hidradenitis Suppurativa		
Claimant 2	$ 373 394	Secondary Malignant Neoplasm Of Liver And Intrahepatic Bile Duct		
Claimant 3	$ 360 834	Unspecified Intestinal Obstruction		
Claimant 4	$ 351 204	Other Congenital Malformations Of Pulmonary Artery		
Claimant 5	$ 348 502	Quadriplegia C1 c4 Incomplete		
Claimant 6	$ 319 405	Multiple Myeloma Not Having Achieved Remission		
Claimant 7	$ 285 456	Cystic Fibrosis With Pulmonary Manifestations		
Claimant 8	$ 239 042	Spinal Stenosis Cervical Region		
Claimant 9	$ 237 418	Single Liveborn Infant Delivered By Cesarean		
Claimant 10	$ 234 288	Encounter For Antineoplastic Chemotherapy		
Claimant 11	$ 230 379	Acute Kidney Failure Unspecified		
Claimant 12	$ 225 695	Acute Lymphoblastic Leukemia Not Having Achieved Remission		
Claimant 13	$ 223 226	Varicose Veins Of Bilateral Lower Extremities With Pain		
Claimant 14	$ 215 547	Cervical Disc Disorder At C6 c7 Level With Myelopathy		
Claimant 15	$ 211 457	Malignant Neoplasm Of Ascending Colon		
Claimant 16	$ 182 311	Malignant Neoplasm Of Transverse Colon		
Claimant 17	$ 169 016	Secondary And Unspecified Malignant Neoplasm Of Lymph Node		
Claimant 18	$ 168 379	Restricted Diagnosis		
Claimant 19	$ 168 321	rheumatoid Arthritis		
Claimant 20	$ 162 511	Cystic Fibrosis With Pulmonary Manifestations		
Claimant 21	$ 147 307	Other Pulmonary Embolism Without Acute Cor Pulmonale		
Claimant 22	$ 142 997	Agranulocytosis Secondary To Cancer Chemotherapy		
Claimant 23	$ 136 418	Acute Pansinusitis Unspecified		
Claimant 24	$ 135 707	Other Spondylosis With Radiculopathy Lumbar Region		
Claimant 25	$ 134 770	Age related Nuclear Cataract Right Eye		
Claimant 26	$ 132 479	Parastomal Hernia Without Obstruction Or Gangrene		
Claimant 27	$ 126 972	Acute Respiratory Failure With Hypoxia		
Claimant 28	$ 126 482	Urgency Of Urination		
Claimant 29	$ 122 385	Nontraumatic Acute Subdural Hemorrhage		
Claimant 30	$ 116 332	Malignant Neoplasm Of Unspecified Site Of Right Female Breast		
Claimant 31	$ 114 243	Calculus Of Kidney		
Claimant 32	$ 113 969	Atherosclerotic Heart Disease Of Native Coronary Artery With		
Claimant 33	$ 104 589	Hepatitis		
Claimant 34	$ 103 749	Premature birth		

Large Claim Listing

GWINNETT COUNTY BOARD OF COMMISSIONERS
Effective 01/01/2016

Contractholder Number 737528
Group Number 737528

This report is designed to meet your need for data in evaluating your benefit plan We have removed individual member identifiers (e g name ID number etc) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations
Amounts below reflect Medical and RX costs

Total Group

Claimants with over $100 000 in claims for 01/01/2016 12/31/2016

Claimant	Amount	ICD 10 Code Description	Relationship	Structure
Claimant 1	$ 538 735	Idiopathic Pulmonary Fibrosis		
Claimant 2	$ 424 795	Malignant Neoplasm Of Transverse Colon		
Claimant 3	$ 392 085	Restricted Diagnosis		
Claimant 4	$ 332 531	Pneumonia Unspecified Organism		
Claimant 5	$ 327 582	Malignant Neoplasm Of Right Testis Unspecified Whether Descended Or Undescended		
Claimant 6	$ 313 957	Spondylosis Without Myelopathy Or Radiculopathy Lumbar Region		
Claimant 7	$ 307 947	Malignant Neoplasm Of Bones Of Skull And Face		
Claimant 8	$ 256 342	Encounter For Antineoplastic Chemotherapy		
Claimant 9	$ 241 579	Patent Ductus Arteriosus		
Claimant 10	$ 238 987	Neuromuscular Scoliosis Thoracolumbar Region		
Claimant 11	$ 230 060	Other Specific Joint Derangements Of Left Hip Not Elsewhere Classified		
Claimant 12	$ 205 273	Gastrointestinal Hemorrhage Unspecified		
Claimant 13	$ 204 253	Postprocedural Hemorrhage Of A Digestive System Organ Or Structure Following A Digestive System Procedure		
Claimant 14	$ 200 446	Restricted Diagnosis		
Claimant 15	$ 199 166	Bloodstream Infection Due To Central Venous Catheter Initial Encounter		
Claimant 16	$ 191 746	Traumatic Subdural Hemorrhage Without Loss Of Consciousness Initial Encounter		
Claimant 17	$ 183 853	Secondary Malignant Neoplasm Of Brain		
Claimant 18	$ 182 193	Malignant Neoplasm Of Rectum		
Claimant 19	$ 175 795	Spondylosis Without Myelopathy Or Radiculopathy Lumbosacral Region		
Claimant 20	$ 170 868	Varicose Veins Of Bilateral Lower Extremities With Pain		
Claimant 21	$ 166 782	Malignant Neoplasm Of Ascending Colon		
Claimant 22	$ 165 205	Cystic Fibrosis With Pulmonary Manifestations		
Claimant 23	$ 161 957	Adolescent Idiopathic Scoliosis Thoracolumbar Region		
Claimant 24	$ 161 796	Malignant Neoplasm Of Rectum		
Claimant 25	$ 158 687	Malignant Carcinoid Tumor Of The Rectum		
Claimant 26	$ 133 822	Other Forms Of Scoliosis Lumbar Region		
Claimant 27	$ 129 842	Restricted Diagnosis		
Claimant 28	$ 127 000	Spinal Stenosis Cervical Region		
Claimant 29	$ 116 442	Sensorineural Hearing Loss Bilateral		
Claimant 30	$ 116 010	Hallux Valgus (acquired) Left Foot		
Claimant 31	$ 115 205	St Elevation (stemi) Myocardial Infarction Involving Other Coronary Artery Of Anterior Wall		
Claimant 32	$ 114 426	Acute Respiratory Failure With Hypoxia		
Claimant 33	$ 112 757	Spastic Diplegic Cerebral Palsy		
Claimant 34	$ 111 532	Neoplasm Related Pain (acute) (chronic)		
Claimant 35	$ 111 257	Pneumonia Unspecified Organism		
Claimant 36	$ 109 229	Restricted Diagnosis		
Claimant 37	$ 108 380	Intervertebral Disc Disorders With Radiculopathy Lumbar Region		
Claimant 38	$ 102 492	Intervertebral Disc Disorders With Radiculopathy Lumbar Region		
Claimant 39	$ 101 659	Unilateral Primary Osteoarthritis Left Knee		
Claimant 40	$ 100 249	Restricted Diagnosis		

Attachment to Disclosure Form

ICD-10-CM Diagnosis Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with or treated for any of the codes listed under the following categories during the current Benefit Period

A00-B99 Certain infectious and parasitic diseases

A40	Streptococcal sepsis
A41	Other Sepsis
B15 B19	Viral Hepatitis
B20	Humanimmunodeficiency virus (HIV) disease

C00 D49 Neoplasms

C00 C96	Malignant neoplasms
D46	Myelodysplastic syndromes

D50-D89 Diseases of the blood and blood-forming organs & disorders involving the immune mechanism

D57	Sickle cell disorders
D59	Acquired hemolytic anemia
D59	Acquired hemolytic anemia
D60 D64	Aplastic and other anemias
D65- 69	Coagulation defects purpura and other hemorrhagic conditions
D70 D77	Other diseases of blood and blood - forming organs
D80 D89	Certain disorders involving the immune mechanism

E00-E89 Endocrine, nutritional and metabolic diseases

E10 E13	Diabetes mellitus
E15 E16	Other disorders of glucose regulation and pancreatic internal secretion
E65-E68	Obesity and other hyper alimentation
E70 E89	Metabolic disorders

F01-F99 Mental, behavioral and neurodevelopmental disorders

F10 1	Alcohol Abuse
F11 1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32 3	Major depressive disorder single episode severe with psychotic feature
F33 1 F33 3	Major Depressive Disorder recurrent
F84 0	Autistic Disorder
F84 2	Rett s Syndrome
F84 5	Asperger s syndrome

G00-G99 Diseases of the nervous system

G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis
G06 G07	Intracranial and intraspinal abscess and Granuloma
G12 21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82 5	Quadraplegia
G83 4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93 1	Anoxic Brain Injury

I00-I99 Diseases of the circulatory system

I20	Angina Pectoris
I21 09 I22	Acute Myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic Ischemic heart disease
I26	Pulmonary embolism
I27	Other Pulmonary heart disease
I28	Other Diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34 I38	Heart Valve Disorders
I42 I43	Cardiomyopathy
I44 I45	Conduction Disorders
I46	Cardiac Arrest
I47 I49	Cardiac Dysrhythmias
I50	Heart Failure
I60 - 161	Subarachnoid Hemorrhage/Intercerebral Hemorrhage
I63	Cerebral infarction
I65 8 I66	Occlusion Of Precerebral/Cerebral Arteries
I67	Other Cerebrovascular disease
I70	Atherosclerosis /Aortic Aneurysm

J00-J99 Diseases of the respiratory system

J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
J84 10 J84 89	Postinflammatory Pulmonary Fibrosis
J98 11 J98 4	Pulmonary Collapse/Respiratory Failure

K00 K95 Diseases of the digestive system

K22	Esophageal obstruction
K25 K28	Ulcers
K31	Other diseases of stomach & duodenum
K50	Crohn s disease
K51	Ulcerative colitis
K55 K64	Diseases of intestine
K65 K68	Diseases of peritoneum & retroperitoneum
K70 K77	Diseases of liver
K83	Diseases of biliary tract
K85 K86	Diseases of pancreatitis
K90 K95	Other diseases of digestive system/Complications of bariatric procedures

M00 M99 Diseases of the musculoskeletal system & connective tissue

M15 M19	Osteoarthritis
M32	Systemic lupus erythematosus
M34	Systemic sclerosis
M41	Scoliosis
M43	Spondylolysis
M50	Cervical disc disorders
M51	Thoracic thoracolumbar & lumbosacral intervertebral disc disorders
M72 6	Necrotizing Fasciitis
M86	Osteomyelitis

N00 N99 Diseases of the genitourinary system

N00 N01	Acute and Rapidly Progressive Nephritic Syndrome
N03	Chronic Nephritic Syndrome
N04	Nephrotic Syndrome
N05 N07	Nephritis and Nephropathy
N08	Glomerular Disorders classified elsewhere
N17	Acute Kidney Failure
N18	Chronic Kidney Disease (CKD)
N19	Renal Failure Unspecified

O00 O9A Pregnancy, childbirth and the puerperium

O09	High Risk Pregnancy
O11	Pre-Existing Hypertension with Pre Eclampsia
O14 O15	Pre-Eclampsia and Eclampsia
O30	Multiple Gestation
O31	Other complications specific to Multiple Gestations

P00 P96 Certain conditions originating in the perinatal period

P07	Disorders of newborn related to short gestation and low birth weight
P10 P15	Birth Trauma
P19	Fetal distress
P23 P28	Other respiratory conditions of newborn
P29	Cardiovascular disorders originating in the perinatal period
P36	Bacterial sepsis of newborn
P52 P53	Intracranial hemorrhage of newborn
P77	Necrotizing enterocolitis of newborn
P91	Other disturbances of cerebral status newborn

Q00 Q99 Congenital malformations, deformations and chromosomal abnormalities

Q00 Q07	Congenital malformations of the nervous system
Q20 Q26	Congenital Cardiac malformations
Q41 Q45	Congenital Anomalies of Digestive system
Q85	Phakomatoses not classified elsewhere
Q87	Congenital malformation syndromes affecting multiple systems
Q89	Other Congenital malformations

R00-R99 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

R07 1 R07 9	Chest Pain
R40 R40 236	Coma
R57 R58	Shock Hemorrhage
R65 2 R65 21	Severe sepsis

S00-T88 Injury, poisoning and certain other consequences of external causes

S02	Fractureof skull and facial bones
S06	Intracranial injury
S07	Crush injury to head
S08	Avulsion and traumatic amputation of part of head
S12 S13	Fracture and injuries of cervical vertebra and other parts of neck
S14 0 S14 15	Injury of nerves and spinal cord at neck level
S22 0	Fracture of thoracic vertebra
S24	Injury of nerves and spinal cord at thorax level
S25	Injury of blood vessels of thorax
S26	Injury of heart
S32 0 S32 2	Fracture of lumbar vertebra
S34	Injury of lumbar and sacral spinal cord and nerves
S35	Injury of blood vessels at abdomen lower back and pelvis
S36 S37	Injury of intra abdominal organs
S48	Traumatic amputation of shoulder and upper arm
S58	Traumatic amputation of elbow and forearm
S68 4 S68 7	Traumatic amputation of hand at wrist level
S78	Traumatic amputation of hip and thigh
S88	Traumatic amputation of lower leg
S98	Traumatic amputation of ankle and foot
T30 T32	Burns and corrosions of multiple body regions
T81 11 T81 12	Postprocedural cardiogenic and septic shock
T82	Complications of cardiac and vascular prosthetic devices implants and grafts
T83 T85	Complications of prosthetic devices implants and grafts
T86	Complications of transplanted organs and tissue
T87	Complications to reattachment and amputation

Z00 Z99 Factors influencing health status and contact with health services

Z37 5 Z37 6	Multiple births
Z38 3 Z38 8	Multiple births
Z48 Z48 298	Encounter for aftercare following organ transplant
Z49	Encounter for care involving renal dialysis
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac and vascular implants and grafts
Z98 85	Transplanted organ removal status
Z99 1	Dependence on respirator
Z99 2	Dependence on dialysis

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/13/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S) AUTHORIZED REPRESENTATIVE OR PRODUCER AND THE CERTIFICATE HOLDER

IMPORTANT If the certificate holder is an ADDITIONAL INSURED the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed If SUBROGATION IS WAIVED subject to the terms and conditions of the policy certain policies may require an endorsement A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s)

PRODUCER Crystal & Company Crystal IBC LLC 32 Old Slip New York NY 10005	CONTACT NAME Reeja Varghese PHONE (A/C, No, Ext) 212 504-5930 FAX (A/C, No) 212 742 2091 E-MAIL ADDRESS reeja varghese@crystalco com
INSURED AMALLI National Retirement Fund Amalgamated Life Insurance Company 333 Westchester Avenue White Plains NY 10604	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A Federal Insurance Company A++XV 20281 INSURER B Great Northern Insurance Company A++XV 20303 INSURER C Pacific Indemnity Company A++XV 20346 INSURER D INSURER E INSURER F

COVERAGES **CERTIFICATE NUMBER** 1734666637 **REVISION NUMBER**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN L AGGREGATE LIMIT APPLIES PER POLICY PRO-JECT X LOC OTHER	Y	Y	35262841	12/31/2017	12/31/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS COMP/OP AGG	$ 1 000 000 $ 1 000 000 $ 10 000 $ 1 000 000 $ 2 000 000 $ 2 000 000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON OWNED AUTOS ONLY	Y	Y	73571185	12/31/2017	12/31/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Deductible	$ 1,000,000 $ $ $ $1 000
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS MADE X DED RETENTION $ 10 000	Y	Y	79631525	12/31/2017	12/31/2018	EACH OCCURRENCE AGGREGATE	$ 10 000 000 $ 10 000 000 $
C	WORKERS COMPENSATION AND EMPLOYERS LIABILITY Y/N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes describe under DESCRIPTION OF OPERATIONS below	N/A	Y	71746159	1/1/2018	1/1/2019	X PER STATUTE OTH ER E L EACH ACCIDENT E L DISEASE EA EMPLOYEE E L DISEASE POLICY LIMIT	 $ 1 000 000 $ 1 000 000 $ 1 000 000

INSURANCE REQUIREMENTS APPROVED BY DATE 12/19/17 PG 1 OF 10

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101 Additional Remarks Schedule may be attached If more space is required)

Coverage applies as required by written contract

Ref Bid BL119 17

Gwinnett County Board of Commissioners is included as an Additional Insured as their interests may appear with respect to General Liability and Automobile Liability 30 Day Notice of Cancellation is included Waiver of Subrogation is included with respect to the General Liability Automobile and Workers Compensation policies

Workers Compensation Evidence of Coverage Only

CERTIFICATE HOLDER

Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville GA 30046

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS

AUTHORIZED REPRESENTATIVE
Crystal & Company

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/1/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S) AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT If the certificate holder is an ADDITIONAL INSURED the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed If SUBROGATION IS WAIVED subject to the terms and conditions of the policy certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s)

PRODUCER	CONTACT NAME	
Crystal & Company Crystal IBC LLC 32 Old Slip New York NY 10005	PHONE (A/C, No, Ext) 800-221 5830	FAX (A/C, No) 800 383-1852
	E-MAIL ADDRESS	

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A	AIG Specialty Insurance Company AXV	26883 (5)
INSURER B		
INSURER C		
INSURER D		
INSURER E		
INSURER F		

INSURED AMALLI

Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains NY 10604

COVERAGES **CERTIFICATE NUMBER** 14232832 **REVISION NUMBER**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED NOTWITHSTANDING ANY REQUIREMENT TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS EXCLUSIONS AND CONDITIONS OF SUCH POLICIES LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS COMP/OP AGG	$
	☐ OTHER							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS LIABILITY Y/N						☐ PER STATUTE ☐ OTH ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N/A (Mandatory In NH)						E L EACH ACCIDENT	$
	If yes describe under DESCRIPTION OF OPERATIONS below						E L DISEASE EA EMPLOYEE	$
							E L DISEASE POLICY LIMIT	$
A	Miscellaneous Professional Liability			013820387	5/30/2017	5/30/2018	Limit of Liability Retention	$2 000 000 $100 000/$250 000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101 Additional Remarks Schedule may be attached if more space is required)

Evidence of Coverage Only

CERTIFICATE HOLDER

Bid BL119 17
Gwinnett County Board of Commissioner
75 Langley Drive
Lawrenceville GA 30046 6935

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS

AUTHORIZED REPRESENTATIVE

Crystal + Company

CHUBB®

Liability Insurance

Endorsement

Policy Period	DECEMBER 31 2016 TO DECEMBER 31 2017
Effective Date	DECEMBER 31 2016
Policy Number	3526-28-41 EUC
Insured	NATIONAL RETIREMENT FUND
Name of Company	GREAT NORTHERN INSURANCE COMPANY
Date Issued	JANUARY 27 2017

This Endorsement applies to the following forms

GENERAL LIABILITY

Under Who Is An Insured, the following provision is added.

Who Is An Insured

Additional Insured - Scheduled Person Or Organization

Persons or organizations shown in the Schedule are **insureds** but they are **insureds** only if you are obligated pursuant to a contract or agreement to provide them with such insurance as is afforded by this policy

However, the person or organization is an **insured** only:

- if and then only to the extent the person or organization is described in the Schedule
- to the extent such contract or agreement requires the person or organization to be afforded status as an **insured,**
- for activities that did not occur in whole or in part, before the execution of the contract or agreement, and
- with respect to damages, loss, cost or expense for injury or damage to which this insurance applies

No person or organization is an **insured** under this provision

- that is more specifically identified under any other provision of the Who Is An Insured section (regardless of any limitation applicable thereto)
- with respect to any assumption of liability (of another person or organization) by them in a contract or agreement. This limitation does not apply to the liability for damages, loss, cost or expense for injury or damage to which this insurance applies, that the person or organization would have in the absence of such contract or agreement.

CHUBB®

Liability Endorsement
(continued)

Conditions

Under Conditions, the following provision is added to the condition titled Other Insurance

Other Insurance – Primary, Noncontributory Insurance – Scheduled Person Or Organization

If you are obligated, pursuant to a contract or agreement, to provide the person or organization shown in the Schedule with primary insurance such as is afforded by this policy then in such case this insurance is primary and we will not seek contribution from insurance available to such person or organization

Schedule

Persons or organizations that you are obligated, pursuant to a contract or agreement, to provide with such insurance as is afforded by this policy

All other terms and conditions remain unchanged.

Authorized Representative

CHUBB®

Policy Conditions

Endorsement

Policy Period	DECEMBER 31 2016 TO DECEMBER 31, 2017
Effective Date	DECEMBER 31 2016
Policy Number	3526-28-41 EUC
Insured	NATIONAL RETIREMENT FUND
Name of Company	GREAT NORTHERN INSURANCE COMPANY
Date Issued	JANUARY 27, 2017

This Endorsement applies to the following forms

COMMON POLICY CONDITIONS

Conditions

Under Conditions, the following condition is added.

Notice Of Cancellation To Scheduled Persons Or Organizations When We Cancel

When we cancel this policy we will notify person(s) or organizations(s) shown in the Schedule at least 30 days (10 days in the event of nonpayment of premium) in advance of the cancellation date

Any failure by us to notify such person(s) or organization(s) will not:

- impose any liability or obligation of any kind upon us or
- invalidate such cancellation

Schedule

Conditions
(continued)

Person(s) or Organization(s)	GWINNETT COUNTY BOARD OF COMMISSIONERS
Address.	75 LANGLEY DRIVE LAWRENCEVILLE GA 30046

All other terms and conditions remain unchanged.

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY PLEASE READ IT CAREFULLY

COMMERCIAL AUTOMOBILE BROAD FORM ENDORSEMENT - NEW YORK

This endorsement modifies insurance provided under the following

BUSINESS AUTO COVERAGE FORM
This endorsement modifies the Business Auto Coverage Form

1 **BROAD FORM INSURED**

A **Subsidiaries and Newly Acquired or Formed Organizations As Insureds**
The Named Insured shown in the Declarations is amended to include

1 Any legally incorporated subsidiary in which you own more than 50% of the voting stock on the effective date of the Coverage Form However the Named Insured does not include any subsidiary that is an insured under any other automobile policy or would be an insured under such a policy but for its termination or the exhaustion of its Limit of Insurance

2 Any organization that is acquired or formed by you and over which you maintain majority ownership However the Named Insured does not include any newly formed or acquired organization

(a) That is an insured under any other automobile policy

(b) That has exhausted its Limit of Insurance under any other policy or

(c) 180 days or more after its acquisition or formation by you unless you have given us written notice of the acquisition or formation

Coverage does not apply to bodily injury' or property damage that results from an accident' that occurred before you formed or acquired the organization

B **Employees as Insureds**
Paragraph A 1 – WHO IS AN INSURED – of SECTION II – LIABILITY COVERAGE is amended to add the following

d Any employee of yours while using a covered auto you don t own hire or borrow in your business or your personal affairs

C **Lessors as Insureds**
Paragraph A 1 – WHO IS AN INSURED – of SECTION II – LIABILITY COVERAGE is amended to add the following

e The lessor of a covered auto while the auto is leased to you under a written agreement if

(1) The agreement requires you to provide direct primary insurance for the lessor and

(2) The auto is leased without a driver

Such leased auto will be considered a covered auto you own and not a covered auto you hire

However the lessor is an insured only for bodily injury' or property damage resulting from the acts or omissions by

(1) You

(2) Any of your employees or agents or

(3) Any person except the lessor or any employee or agent of the lessor operating an auto with the permission of any of 1 and/or 2 above

D **Persons And Organizations As Insureds Under A Written Insured Contract**
Paragraph A 1 – WHO IS AN INSURED – of SECTION II – LIABILITY COVERAGE is amended to add the following

f Any person or organization with respect to the operation maintenance or use of a covered auto provided that you and such person or organization have agreed under an express provision in a written insured contract' written agreement or a written permit issued to you by a governmental or public authority to add such person or organization to this policy as an insured

However such person or organization is an insured only

(1) with respect to the operation maintenance or use of a covered auto and

(2) for bodily injury' or property damage caused by an accident which takes place after
(a) You executed the insured contract or written agreement or
(b) The permit has been issued to you

2 **AMENDED FELLOW EMPLOYEE EXCLUSION**
EXCLUSION 5 – FELLOW EMPLOYEE – of SECTION II – LIABILITY COVERAGE is amended to add the following
However this exclusion only applies if the fellow employee is entitled to benefits under any of the following workers compensation unemployment compensation or disability benefits law or any similar law

3 **PHYSICAL DAMAGE – ADDITIONAL TEMPORARY TRANSPORTATION EXPENSE COVERAGE**
Paragraph A 4 a – TRANSPORTATION EXPENSES – of SECTION III – PHYSICAL DAMAGE COVERAGE is amended to provide a limit of $50 per day for temporary transportation expense subject to a maximum limit of $1 000

4 **RENTAL AGENCY EXPENSE**
Paragraph A 4 – COVERAGE EXTENSIONS – of SECTION III – PHYSICAL DAMAGE COVERAGE is amended to add the following
c **Rental Expense**
We will pay the following expenses that you or any of your employees are legally obligated to pay because of a written contract or agreement entered into for use of a rental vehicle in the conduct of your business
MAXIMUM WE WILL PAY FOR ANY ONE CONTRACT OR AGREEMENT
1 $2 500 for loss of income incurred by the rental agency during the period of time that vehicle is out of use because of actual damage to or loss of that vehicle including income lost due to absence of that vehicle for use as a replacement
2 $2 500 for decrease in trade-in value of the rental vehicle because of actual damage to that vehicle arising out of a covered loss and
3 $2 500 for administrative expenses incurred by the rental agency as stated in the contract or agreement
4 $7 500 maximum total amount for paragraphs 1 2 and 3 combined

5 **EXTRA EXPENSE – BROADENED COVERAGE**
Paragraph A 4 – COVERAGE EXTENSIONS – of SECTION III – PHYSICAL DAMAGE COVERAGE is amended to add the following
d **Recovery Expense**
We will pay for the expense of returning a stolen covered auto to you

6 **AIRBAG COVERAGE**
Paragraph B 3 a EXCLUSIONS – of SECTION III – PHYSICAL DAMAGE COVERAGE does not apply to the accidental or unintended discharge of an airbag Coverage is excess over any other collectible insurance or warranty specifically designed to provide this coverage

7 **AUDIO, VISUAL AND DATA ELECTRONIC EQUIPMENT - BROADENED COVERAGE**
Paragraph C 1 b – LIMIT OF INSURANCE - of SECTION III - PHYSICAL DAMAGE is deleted and replaced with the following
2 $2 000 is the most we will pay for loss in any one accident to all electronic equipment that reproduces receives or transmits audio visual or data signals which at the time of 'loss is
(1) Permanently installed in or upon the covered "auto' in a housing opening or other location that is not normally used by the 'auto' manufacturer for the installation of such equipment
(2) Removable from a permanently installed housing unit as described in Paragraph 2 a above or is an integral part of that equipment or
(3) An integral part of such equipment

8 **GLASS REPAIR – WAIVER OF DEDUCTIBLE**
Under Paragraph D - DEDUCTIBLE – of SECTION III – PHYSICAL DAMAGE COVERAGE the following is added
No deductible applies to glass damage if the glass is repaired rather than replaced

9 **TWO OR MORE DEDUCTIBLES**
Paragraph D - DEDUCTIBLE – of SECTION III – PHYSICAL DAMAGE COVERAGE is amended to add the following
If this Coverage Form and any other Coverage Form or policy issued to you by us that is not an automobile policy or Coverage Form applies to the same accident the following applies
1 If the deductible under this Business Auto Coverage Form is the smaller (or smallest) deductible it will be waived or
2 If the deductible under this Business Auto Coverage Form is not the smaller (or smallest) deductible it will be reduced by the amount of the smaller (or smallest) deductible

10 **AMENDED DUTIES IN THE EVENT OF ACCIDENT, CLAIM, SUIT OR LOSS**
Paragraph A 2 a - DUTIES IN THE EVENT OF AN ACCIDENT CLAIM SUIT OR LOSS of SECTION IV - BUSINESS AUTO CONDITIONS is deleted and replaced with the following
a In the event of accident' claim suit or loss you must notify us as soon as reasonably possible when the accident is known to
(1) You or your authorized representative if you are an individual

THIS ENDORSEMENT CHANGES THE POLICY PLEASE READ IT CAREFULLY

NOTICE OF CANCELLATION SCHEDULED PERSON(S) OR ORGANIZATION(S)

This endorsement modifies insurance provided under the following

BUSINESS AUTO COVERAGE FORM
BUSINESS AUTO PHYSICAL DAMAGE COVERAGE FORM
GARAGE COVERAGE FORM
TRUCKERS COVERAGE FORM
MOTOR CARRIER COVERAGE FORM

With respect to the coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by this endorsement

SCHEDULE

Name of Person(s) or Organization(s)
GWINNETT COUNTY BOARD OF COMMISSIONERS

Address
75 LANGLEY DRIVE
LAWRENCEVILLE GA 30046

Under Common Policy Conditions the following condition is added

NOTICE OF CANCELLATION – SCHEDULED PERSON(S) OR ORGANIZATION(S)

When we cancel this policy we will notify the person(s) or organization(s) described in the SCHEDULE at least 30 days (10 days in the event of nonpayment of premium) in advance of the cancellation date

Any failure by us to notify such person(s) or organization(s) will not

- Impose any liability or obligation of any kind upon us, or
- Invalidate such cancellation

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 124
(4-84)

WC 00 03 13

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy)

This endorsement, effective on 01/01/17 (DATE) at 12 01 A M standard time, forms a part of

Policy No (18)7174-61-59 of the PACIFIC INDEMNITY COMPANY (NAME OF INSURANCE COMPANY)

Issued to NATIONAL RETIREMENT FUND

Endorsement No

_____
Authorized Representative

We have the right to recover our payments from anyone liable for an injury covered by this policy We will not enforce our right against the person or organization named in the Schedule This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us *

This agreement shall not operate directly or indirectly to benefit any one not named in the Schedule

Schedule

AS REQUIRED PER WRITTEN CONTRACT

Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville GA 30046 6935
(tel) 770 822 8720 (fax) 770 822 8735

gwinnettcounty

BL119-17, Individual Stop Loss Coverage on an Annual Contract

CONTRACTOR AFFIDAVIT AND AGREEMENT
(THIS FORM SHOULD BE FULLY COMPLETED AND RETURNED WITH YOUR SUBMITTAL)

By executing this affidavit, the undersigned contractor verifies its compliance with The Illegal Reform Enhancements for 2013 stating affirmatively that the individual firm, or corporation which is contracting with the Gwinnett County Board of Commissioners has registered with and is participating in a federal work authorization program* [any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees pursuant to the Immigration Reform and Control Act in accordance with the applicability provisions and deadlines established therein

The undersigned further agrees that, should it employ or contract with any subcontractor(s) in connection with the physical performance of services or the performance of labor pursuant to this contract with the Gwinnett County Board of Commissioners contractor will secure from such subcontractor(s) similar verification of compliance with the Illegal Immigration Reform and Enforcement Act on the Subcontractor Affidavit provided in Rule 300 10 01- 08 or a substantially similar form Contractor further agrees to maintain records of such compliance and provide a copy of each such verification to the Gwinnett County Board of Commissioners at the time the subcontractor(s) is retained to perform such service

597204
E Verify * User Identification Number

September, 2010
Date Registered

Amalgamated Life Insurance Company
Legal Company Name

333 Westchester Avenue
Street Address

White Plains, NY 10604
City/State/Zip Code

BY _____ Authorized ~~Officer~~ or Agent
(Contractor Signature)

11/15/17
Date

Executive Vice President
Title of Authorized Officer or Agent of Contractor

John A Thornton
Printed Name of Authorized Officer or Agent

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
15th DAY OF November 2017

Sandra Stueben
Notary Public
My Commission Expires

SANDRA STUEBEN
NOTARY PUBLIC STATE OF NEW YORK
No 01ST6225743
Qualified in Dutchess County
My Commission Expires July 30, 2018

For Gwinnett County Use Only

Document ID # _____

Issue Date _____

Initials _____

* As of the effective date of O C G A 13 10 91 the applicable federal work authorization program is E Verify operated by the U S Citizenship and Immigration Services Bureau of the U S Department of Homeland Security in conjunction with the Social Security Administration (SSA)

Rev 6 20 13

Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville GA 30046 6935
(tel) 770 822 8720 • (fax) 770 822 8735

gwinnettcounty

BL119-17, Individual Stop Loss Coverage on an Annual Contract

CODE OF ETHICS AFFIDAVIT

(THIS FORM SHOULD BE FULLY COMPLETED AND RETURNED WITH YOUR SUBMITTAL AND WILL BE REQUIRED PRIOR TO EVALUATION)

In accordance with Section 54 33 of the Gwinnett County Code of Ordinances the undersigned bidder/proposer makes the following full and complete disclosure under oath, to the best of his/her knowledge, of the name(s) of all elected officials whom it employs or who have a direct or indirect pecuniary interest in or with the bidder/proposer, its affiliates or its subcontractors

1 Amalgamated Life Insurance Company
(Company Submitting Bid/Proposal)

2 (Please check ☑ **one** box below)

☒ No information to disclose *(complete only section 4 below)*

☐ Disclosed information below *(complete section 3 & section 4 below)*

3 (if additional space is required please attach list)

Gwinnett County Elected Official Name _____ Gwinnett County Elected Official Name _____

Gwinnett County Elected Official Name _____ Gwinnett County Elected Official Name _____

4

BY _____
Authorized Officer or Agent Signature

John A. Thornton
Printed Name of Authorized Officer or Agent

Executive Vice President
Title of Authorized Officer or Agent of Contractor

Sworn to and subscribed before me this
15th day of November 2017

Sandra Stueben
Notary Public

SANDRA STUEBEN
NOTARY PUBLIC STATE OF NEW YORK
No 01ST6225743
Qualified in Dutchess County
My Commission Expires July 26, 2018
(seal)

Note See Gwinnett County Code of Ethics Ordinance EO2011 Sec 54 33 The ordinance will be available to view in its entirety at www.gwinnettcounty.com

7 14 17

Amalgamated Life Insurance
amalgamatedlife com

Bid BL119-17

A PROPOSAL FOR STOP LOSS SPECIFICALLY DESIGNED FOR

GWINNETT COUNTY

BOARD of COMMISSIONERS

Your Sales Executive	Michael Schaefer
Telephone Number	914 539 6347
Email Address	mschaefer@amalgamatedlife com
Effective Date	January 1 2018
Date Prepared	November 27 2017
Date Proposal Expires	December 31 2017

Underwritten by

Amalgamated Life Insurance Company

333 Westchester Avenue

White Plains NY 10604

Amalgamated Life
Life Accident Disability

TABLE OF CONTENTS

Amalgamated Life
Life Accident Disability

Individual stop loss insurance provides reimbursement to an employer for eligible claims paid over the deductible amount for any covered employee or dependent Once the individual deductible is satisfied we will pay the employer amounts after the deductible up to the Individual Maximum Lifetime Benefit times the stop-loss coinsurance level

Stop Loss Terms

Benefits Covered	Medical (with Prescription drugs)
Specific Stop Loss Benefits	Duplicates current benefit plan (see E&Ls)
Specific Exclusions & Limitations (E&Ls)	See assumed list below
Specific Individual Deductible	$325,000 / $350 000 / $375 000
Specific Individual Maximum Lifetime Benefit	Unlimited
Specific Individual Maximum Annual Benefit	Unlimited
Stop-Loss Coinsurance Level	100%
Stop Loss Basis	PAID
Incurred Basis Description	Prior to Effective Date of January 1 2018
Paid Basis Description	January 1 2018 thru December 31 2018

Amalgamated Life
Life Accident Disability

Stop Loss Insurance - Exclusions and Limitations (E&L's)

This proposal assumes that your plan does NOT pay for (with similar wording) If not we reserve the right to adjust the enclosed rates

- Benefits paid which are not covered under the Employee Benefit Plan
- Benefits which would not have been paid if benefits had been coordinated with Medicare whether or not Medicare is elected by the Covered Individual
- Benefits paid under the Employee Benefit Plan which would not have been paid if benefits had been coordinated under the provisions of the National Association of Insurance Commissioners Model COB Guidelines as adopted in the state of issuance
- Benefits paid for occupational injury or sickness including benefits eligible for payment under a worker's compensation or similar law whether or not the Plan Sponsor has elected to provide such coverage
- Benefits paid under the Employee Benefit Plan which are in excess of reasonable and customary charges
- Benefits which are not eligible expenses under the terms of the Employee Benefit Plan Provider network fees or charges including, but not limited to, PPO, EPO and POS access fees and HMO capitation fees or charges
- Expenses which are Experimental or Investigational
- Benefits paid for expenses incurred by individuals who are U S Citizens and are assigned outside of the U S or traveling outside of the U S , except in emergency situations Emergency situations are defined as instances of a serious injury, the onset of a serious condition which requires immediate medical intervention to prevent death a serious impairment of health, or the potential for imminent dangerous activity by the individual to self or others Emergencies do not include elective care or care of minor illness or injury Individuals who are Foreign Nationals temporarily located in the U S and receiving a W-2 from the employer may be covered under this Policy All other Foreign Nationals will not be covered under this Policy
- Charges for treatment not recommended and approved by a physician as the term "physician" or its equivalent is defined under the Employee Benefit Plan
- Punitive or other damages assessed against the Plan Sponsor Third Party Claim Administrator or any other party associated with the Employee Benefit Plan

- The cost of claim administration and any expense of litigation with individual claimants
- Benefits currently paid under a fully insured contract

Stop Loss Premium

Rate Effective Date = January 1, 2018

Monthly Specific Stop Loss Premium Rates **Medical with Rx – PAID Contract Basis** **No New Laser with 49% Rate Cap**			
Enrollment Single – 780 Family – 1,381 Total – 2,161	**Specific Deductible** $ 325,000	**Specific Deductible** $ 350 000	**Specific Deductible** $ 375 000
Specific Composite Rate (Monthly)	$ 42 32	$ 38 09	$ 35 04
Specific Premium (Annual)	**$ 1,097,455**	**$ 987,914**	**$ 908,657**

Additional Quote Specifics

- If you use ALICARE Medical Management (AMM) as your case manager vendor a 3% discount will be applied to the stop loss rates/premium
- Proposal assumes that you will submit the following final disclosure documentation with a signed Disclosure form (to be provided) within 30 days of coverage effective date for Amalgamated Life's review
  - Pre-Certification report
  - Pended Claims report
  - Trigger Diagnosis Report
  - Updated Large Loss Report (paid claims in excess of $25 000) with Case Management Notes for the period 1/1/2017 through 9/30/2017

Amalgamated Life reserves the right to laser deny coverage or limit the run-in claim amount with respect to any covered life if applicable The final premium quote will be provided to you within 30 days of receipt of your final disclosure Coverage cannot be bound without completing the final disclosure review process

The above request has been satisfied (accepted with data through 9/30/2017), and the quoted Rates above are firm All claimants are ok at the current Specific deductible

- Proposal assumes that Run-in claim amounts will be limited to the following allowable maximum 15% of the individual stop loss deductible per member – N/A
- Proposal assumes AETNA will be the Network and Administrator utilizing a PPO product Notification of a change in either is required and may result in a change of rates or terms under the policy
- Proposal requires the policyholder to maintain Utilization Review and Case Management programs contracted with a qualified firm who will provide Amalgamated Life with monthly clinical review information when requested
- Proposal assumes a monthly Diagnosis Trigger and 50% Threshold Report will be provided in a timely manner to Amalgamated Life
- Proposal assumes Commission of 10%
- Proposal assumes Situs of group is GA
- Proposal assumes inclusion of Specific Advance funding feature

Notes

- Active disabled, Non-Medicare Retirees and COBRA employees are covered with their dependents
- Medicare retirees are not covered
- Rates may be adjusted if enrollment shifts by 10%
- Proposal covers non-occupational loss
- Proposal assumes claims are paid at lesser of plan basis or 90th percentile of UCR Proposal assumes no lives are fully-insured
- Proposal assumes an annual electronic census
- Amalgamated Life does not require a group to apply for the ERRP (Early Retiree Reinsurance Program under the Patient Protection and Affordable Care Act) However, if a group does apply and has purchased stop-loss coverage for employees eligible under ERRP, Amalgamated Life's procedure for an ERRP claim is to pay the claim and then await government reimbursement If a claim does not exceed the stop loss deductible no subrogation would occur However, if a claim does exceed the stop loss deductible that portion of the ERRP claim reimbursement that would lower the stop loss reimbursement would be subrogated

This Proposal is presented by Amalgamated Life Insurance Company

An A (Excellent) rated company by A M Best domiciled in the State of New York at

333 Westchester Avenue White Plains NY 10604, Phone 914-367-5000

Amalgamated Life Insurance
amalgamatedlife com

Amalgamated Life
Life Accident Disability

MEDICAL STOP LOSS INSURANCE SIGNATURE PAGE Bid BL119-17

If you accept the offer as stated in the enclosed letter, please sign and return this form The form should be signed by the Plan Sponsor or an authorized representative A new policy will be issued as soon as possible with any changes specified in the letter If no changes are specified, the terms in the current policy will apply

Name of Applicant	**Gwinnett County Board of Commissioners**
Stop Loss Policy #	**SL1079**
TPA	**AETNA**
Renewal Effective Date	**01/01/2018**
Please circle one	**OPTION 1 ($325,000)** **OPTION 2 ($350,000)**
	OPTION 3 ($375,000)

Please forward this signature page and completed and signed disclosure form to

John-Patrick Hull
AVP, Underwriting
Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, NY 10604
jhull@amalgamatedlife com

Gwinnett County Board of Commissioners hereby agrees to the renewal rates and factors, as well as any other changes, outlined in the attached renewal letter

Plan Sponsor _____

Signature _____

Name _____

Title _____

Date _____

Amalgamated Life
Life Accident Disability

Amalgamated Life Insurance
amalgamatedlife com

Michael J Schaefer
Managing Director of Strategic Partnerships
Amalgamated Life Insurance Company
P O Box 1476
Geneva FL 32732 1476
T 914 539 6347

Gwinnett County Financial Services
Purchasing Division
BL119-17
Gwinnett County Government
75 Langley Drive, 2nd Floor
Lawrenceville, Georgia 30046

November 15 2017

Re Bid BL119-17 Individual Stop Loss Coverage

It is my pleasure to present to you our proposal for Stop Loss for the Gwinnett County Board of Commissioners Our renewal effective date is 1/1/18 Please note a few items

1 We are able to comply with all the request and terms as outlined
2 We included a No New Laser" and Maximum Rate Increase of 49% provision for renewals as part of the proposal
3 There are no lasers for Policy Year 2018
4 We did include a new Expedited Claims Process in our bid to speed up the claims process Details enclosed with a performance guarantee
5 We are licensed in all 50 state and are rated "A", excellent by A M Best and have been for 42 consecutive years We also have an "A-" excellent Weiss rating
6 Our quote is firm and final with only the enclosed Disclosure Form and Renewal/Proposal letter needing a signature A new application is not necessary as you are a current client

Should you have any questions or need any additional information please don't hesitate to contact me

Thank you again for the opportunity and best regards,

Mike

Michael J Schaefer

Amalgamated Life
Life Accident Disability

Amalgamated Life Insurance
amalgamatedlife com

Bid BL119-17

A PROPOSAL FOR STOP LOSS SPECIFICALLY DESIGNED FOR

GWINNETT COUNTY

BOARD of COMMISSIONERS

Your Sales Executive	Michael Schaefer
Telephone Number	914 539 6347
Email Address	mschaefer@amalgamatedlife com
Effective Date	January 1 2018
Date Prepared	November 15 2017
Date Proposal Expires	December 31 2017

Underwritten by

Amalgamated Life Insurance Company

333 Westchester Avenue

White Plains NY 10604

Amalgamated Life
Life Accident Disability

TABLE OF CONTENTS

Amalgamated Life
Life Accident Disability

Individual stop loss insurance provides reimbursement to an employer for eligible claims paid over the deductible amount for any covered employee or dependent Once the individual deductible is satisfied, we will pay the employer amounts after the deductible up to the Individual Maximum Lifetime Benefit times the stop-loss coinsurance level

Stop Loss Terms

Benefits Covered	Medical (with Prescription drugs)
Specific Stop Loss Benefits	Duplicates current benefit plan (see E&Ls)
Specific Exclusions & Limitations (E&Ls)	See assumed list below
Specific Individual Deductible	$325 000 / $350 000 / $375 000
Specific Individual Maximum Lifetime Benefit	Unlimited
Specific Individual Maximum Annual Benefit	Unlimited
Stop-Loss Coinsurance Level	100%
Stop Loss Basis	PAID
Incurred Basis Description	Prior to Effective Date of January 1 2018
Paid Basis Description	January 1 2018 thru December 31 2018

Amalgamated Life
Life Accident Disability

Stop Loss Insurance - Exclusions and Limitations (E&L's)

This proposal assumes that your plan does NOT pay for (with similar wording) If not we reserve the right to adjust the enclosed rates

- Benefits paid which are not covered under the Employee Benefit Plan
- Benefits which would not have been paid if benefits had been coordinated with Medicare whether or not Medicare is elected by the Covered Individual
- Benefits paid under the Employee Benefit Plan which would not have been paid if benefits had been coordinated under the provisions of the National Association of Insurance Commissioners Model COB Guidelines as adopted in the state of issuance
- Benefits paid for occupational injury or sickness including benefits eligible for payment under a worker's compensation or similar law whether or not the Plan Sponsor has elected to provide such coverage
- Benefits paid under the Employee Benefit Plan which are in excess of reasonable and customary charges
- Benefits which are not eligible expenses under the terms of the Employee Benefit Plan Provider network fees or charges including but not limited to PPO EPO and POS access fees and HMO capitation fees or charges
- Expenses which are Experimental or Investigational
- Benefits paid for expenses incurred by individuals who are U S Citizens and are assigned outside of the U S or traveling outside of the U S except in emergency situations Emergency situations are defined as instances of a serious injury the onset of a serious condition which requires immediate medical intervention to prevent death a serious impairment of health or the potential for imminent dangerous activity by the individual to self or others Emergencies do not include elective care or care of minor illness or injury Individuals who are Foreign Nationals temporarily located in the U S and receiving a W-2 from the employer may be covered under this Policy All other Foreign Nationals will not be covered under this Policy
- Charges for treatment not recommended and approved by a physician as the term physician" or its equivalent is defined under the Employee Benefit Plan
- Punitive or other damages assessed against the Plan Sponsor Third Party Claim Administrator or any other party associated with the Employee Benefit Plan

- The cost of claim administration and any expense of litigation with individual claimants
- Benefits currently paid under a fully insured contract

Stop Loss Premium

Rate Effective Date = January 1, 2018

Monthly Specific Stop Loss Premium Rates **Medical with Rx – PAID Contract Basis** **No New Laser with 49% Rate Cap**			
Enrollment Single – 780 Family – 1,381 Total – 2 161	**Specific Deductible** $ 325 000	**Specific Deductible** $ 350 000	**Specific Deductible** $ 375,000
Specific Composite Rate (Monthly)	$ 44 72	$ 39 94	$ 36 51
Specific Premium (Annual)	**$ 1,159,679**	**$ 1,035,724**	**$ 946,777**

Additional Quote Specifics

- If you use ALICARE Medical Management (AMM) as your case manager vendor a 3% discount will be applied to the stop loss rates/premium
- Proposal assumes that you will submit the following final disclosure documentation with a signed Disclosure form (to be provided) within 30 days of coverage effective date for Amalgamated Life s review
    - Pre-Certification report
    - Pended Claims report
    - Trigger Diagnosis Report
    - Updated Large Loss Report (paid claims in excess of $25 000) with Case Management Notes for the period 1/1/2017 through 9/30/2017

  Amalgamated Life reserves the right to laser deny coverage or limit the run-in claim amount with respect to any covered life if applicable The final premium quote will be provided to you within 30 days of receipt of your final disclosure Coverage cannot be bound without completing the final disclosure review process

  The above request has been satisfied (accepted with data through 9/30/2017), and the quoted Rates above are firm All claimants are ok at the current Specific deductible

- Proposal assumes that Run-in claim amounts will be limited to the following allowable maximum 15% of the individual stop loss deductible per member – N/A
- Proposal assumes AETNA will be the Network and Administrator utilizing a PPO product Notification of a change in either is required and may result in a change of rates or terms under the policy
- Proposal requires the policyholder to maintain Utilization Review and Case Management programs contracted with a qualified firm who will provide Amalgamated Life with monthly clinical review information when requested
- Proposal assumes a monthly Diagnosis Trigger and 50% Threshold Report will be provided in a timely manner to Amalgamated Life
- Proposal assumes Commission of 10%
- Proposal assumes Situs of group is GA
- Proposal assumes inclusion of Specific Advance funding feature

Notes

- Active disabled Non-Medicare Retirees and COBRA employees are covered with their dependents
- Medicare retirees are not covered
- Rates may be adjusted if enrollment shifts by 10%
- Proposal covers non-occupational loss
- Proposal assumes claims are paid at lesser of plan basis or 90th percentile of UCR Proposal assumes no lives are fully-insured
- Proposal assumes an annual electronic census
- Amalgamated Life does not require a group to apply for the ERRP (Early Retiree Reinsurance Program under the Patient Protection and Affordable Care Act) However if a group does apply and has purchased stop-loss coverage for employees eligible under ERRP Amalgamated Life s procedure for an ERRP claim is to pay the claim and then await government reimbursement If a claim does not exceed the stop loss deductible no subrogation would occur However if a claim does exceed the stop loss deductible that portion of the ERRP claim reimbursement that would lower the stop loss reimbursement would be subrogated

This Proposal is presented by Amalgamated Life Insurance Company

An A (Excellent) rated company by A M Best domiciled in the State of New York at

333 Westchester Avenue White Plains NY 10604 Phone 914-367-5000

Amalgamated Life
Life Accident Disability

MEDICAL STOP LOSS INSURANCE SIGNATURE PAGE Bid BL119-17

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Please circle one	**OPTION 1 ($325,000)** **OPTION 2 ($350,000)**
	OPTION 3 ($375,000)

Please forward this signature page and completed and signed disclosure form to

John-Patrick Hull
AVP, Underwriting
Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, NY 10604
jhull@amalgamatedlife com

Gwinnett County Board of Commissioners hereby agrees to the renewal rates and factors, as well as any other changes, outlined in the attached renewal letter

Plan Sponsor _____

Signature SIGNATURE NOT REQUIRED

Name _____

Title _____

Date _____

Amalgamated Life
Life Accident Disability

John A Thornton
Executive Vice President Sales & Marketing
Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains NY 10604
T 914 367 5511 F 914 367 2511
jthornton@amalgamatedlife com

November 14, 2017

Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville, GA 30046

RE Gwinnett County Bid for Specific Stop Loss Coverage
GCBOC Invitation to Bid BL119-17 - Stop Loss Policy

To Whom It May Concern

Amalgamated Life hereby agrees to waive our right under Section IV 3 of our Excess Loss policy regarding adjusting premium rates during the policy year from January 1, 2018 through December 31, 2018, if the enrollment of the group changes by more than 10% of the enrollment at inception (1/1/2018)

Amalgamated Life will administratively allow a change in enrollment of +/- 15% at inception (1/1/2018) before we would consider any action

Sincerely,

John A Thornton
EVP, Sales & Marketing

Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville GA 30046 6935
(tel) 770 822 8720 • (fax) 770 822 8735

gwinnettcounty

November 09, 2017

ADDENDUM 1
BL119-17
Individual Stop Loss Coverage on an Annual Contract

It has come to our attention that 2016 claims provided may be incomplete We will provide complete 2016 claims as soon as possible

This addendum should be signed in the space provided below and returned with your bid Failure to do so may result in your bid being deemed non-responsive

Thank you

Dana Garland

Dana Garland, CPPB
Purchasing Associate III

Company Name Amalgamated Life Insurance Company

Authorized Representative _____

Department of Financial Services
Purchasing Division

75 Langley Drive Lawrenceville GA 30046 6935
(tel) 770 822 8720 (fax) 770 822 8735

gwinnettcounty

November 13, 2017

ADDENDUM 2
BL119-17
Individual Stop Loss Coverage on an Annual Contract

Please see attached complete 2016 large claims data

This addendum should be signed in the space provided below and returned with your bid. Failure to do so may result in your bid being deemed non-responsive

Thank you

Dana Garland

Dana Garland, CPPB
Purchasing Associate III

Company Name Amalgamated Life Insurance Company

Authorized Representative _____

aetna℠

Large Claim Listing

GWINNETT COUNTY BOARD OF COMMISSIONERS
Effective 01/01/2016

Contractholder Number - 737528
Group Number - 737528

This report is designed to meet your need for data in evaluating your benefit plan We have removed individual member identifiers (e g name ID number etc) because most plan sponsors find that their needs can be met without identifiers and also to comply with state and federal health information privacy regulations

- Amounts below reflect Medical and RX costs

Total Group

Claimants with over $100,000 in claims for 01/01/2016 - 12/31/2016

Claimant	Amount	ICD-10 Code Description	Status
Claimant 1	$ 538 735	Idiopathic Pulmonary Fibrosis	
Claimant 2	$ 424 795	Malignant Neoplasm Of Transverse Colon	
Claimant 3	$ 392 085	Restricted Diagnosis	
Claimant 4	$ 332 531	Pneumonia Unspecified Organism	
Claimant 5	$ 327 582	Malignant Neoplasm Of Right Testis Unspecified Whether Descended Or Undescended	
Claimant 6	$ 313 957	Spondylosis Without Myelopathy Or Radiculopathy Lumbar Region	
Claimant 7	$ 307 947	Malignant Neoplasm Of Bones Of Skull And Face	
Claimant 8	$ 256 342	Encounter For Antineoplastic Chemotherapy	
Claimant 9	$ 241 579	Patent Ductus Arteriosus	
Claimant 10	$ 238 987	Neuromuscular Scoliosis Thoracolumbar Region	
Claimant 11	$ 230 060	Other Specific Joint Derangements Of Left Hip Not Elsewhere Classified	
Claimant 12	$ 205 273	Gastrointestinal Hemorrhage Unspecified	
Claimant 13	$ 204 253	Postprocedural Hemorrhage Of A Digestive System Organ Or Structure Following A Digestive System Procedure	
Claimant 14	$ 200 446	Restricted Diagnosis	
Claimant 15	$ 199 166	Bloodstream Infection Due To Central Venous Catheter Initial Encounter	
Claimant 16	$ 191 746	Traumatic Subdural Hemorrhage Without Loss Of Consciousness Initial Encounter	
Claimant 17	$ 183 853	Secondary Malignant Neoplasm Of Brain	
Claimant 18	$ 182 193	Malignant Neoplasm Of Rectum	
Claimant 19	$ 175 795	Spondylosis Without Myelopathy Or Radiculopathy Lumbosacral Region	
Claimant 20	$ 170 868	Varicose Veins Of Bilateral Lower Extremities With Pain	
Claimant 21	$ 166 782	Malignant Neoplasm Of Ascending Colon	

Claimant 22	$	165 205	Cystic Fibrosis With Pulmonary Manifestations
Claimant 23	$	161 957	Adolescent Idiopathic Scoliosis Thoracolumbar Region
Claimant 24	$	161 796	Malignant Neoplasm Of Rectum
Claimant 25	$	158 687	Malignant Carcinoid Tumor Of The Rectum
Claimant 26	$	133 822	Other Forms Of Scoliosis Lumbar Region
Claimant 27	$	129 842	Restricted Diagnosis
Claimant 28	$	127 000	Spinal Stenosis Cervical Region
Claimant 29	$	116 442	Sensorineural Hearing Loss Bilateral
Claimant 30	$	116 010	Hallux Valgus (acquired) Left Foot
Claimant 31	$	115 205	St Elevation (stemi) Myocardial Infarction Involving Other Coronary Artery Of Anterior Wall
Claimant 32	$	114 426	Acute Respiratory Failure With Hypoxia
Claimant 33	$	112 757	Spastic Diplegic Cerebral Palsy
Claimant 34	$	111 532	Neoplasm Related Pain (acute) (chronic)
Claimant 35	$	111 257	Pneumonia Unspecified Organism
Claimant 36	$	109 229	Restricted Diagnosis
Claimant 37	$	108 380	Intervertebral Disc Disorders With Radiculopathy Lumbar Region
Claimant 38	$	102 492	Intervertebral Disc Disorders With Radiculopathy Lumbar Region
Claimant 39	$	101 659	Unilateral Primary Osteoarthritis Left Knee
Claimant 40	$	100 249	Restricted Diagnosis

Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville GA 30046 6935
(tel) 770 822 8720 • (fax) 770 822 8735

gwinnettcounty

November 16, 2017

ADDENDUM 3
BL119-17
Individual Stop Loss Coverage on an Annual Contract

Q1 What is the number of Safety Employees for Police and Fire?
A1 Number of safety employees for fire and police is 1,700

This addendum should be signed in the space provided below and returned with your bid Failure to do so may result in your bid being deemed non-responsive

Thank you

Dana Garland

Dana Garland, CPPB
Purchasing Associate III

Company Name Amalgamated Life Insurance Company

Authorized Representative Jr-Patrick Hall

Department of Financial Services
Purchasing Division

75 Langley Drive • Lawrenceville GA 30046 6935
(tel) 770 822 8720 (fax) 770 822.8735

gwinnettcounty

November 17, 2017

ADDENDUM 4
BL119-17
Individual Stop Loss Coverage on an Annual Contract

The bid opening has been postponed until November 20, 2017 at 3 00pm. All bids are due by 2 50pm on November 20, 2017

This addendum should be signed in the space provided below and returned with your bid Failure to do so may result in your bid being deemed non-responsive

Thank you

Dana Garland

Dana Garland, CPPB
Purchasing Associate III

Company Name Amalgamated Life Ins. Co

Authorized Representative [signature]

11/17/17

STATE OF GEORGIA
OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER
CERTIFICATE OF AUTHORITY

WHEREAS **AMALGAMATED LIFE INSURANCE COMPANY** ORGANIZED UNDER THE LAWS AND REGULATIONS OF THE STATE OF NEW YORK HAVING COMPLIED WITH THE REQUIREMENTS OF THE LAWS AND REGULATIONS OF THIS STATE AS ARE APPLICABLE TO SUCH ORGANIZATION IT IS HEREBY LICENSED TO TRANSACT THE BUSINESS OF INSURANCE IN THE STATE OF GEORGIA ACCORDING TO THE LAWS THEREOF WITH RESPECT TO THE FOLLOWING CLASSES AND/OR LINES OF INSURANCE

LIFE ACCIDENT AND SICKNESS

NOTHING CONTAINED IN THIS LICENSE AUTHORIZES THE LICENSEE TO ENGAGE IN OR WRITE ANY CLASSES OR KINDS OF INSURANCE IN THIS STATE FOR WHICH THE LICENSEE IS NOT AUTHORIZED IN ITS STATE OF DOMICILE

PURSUANT TO O C G A SECTION 33-3-16(a) THIS CERTIFICATE OF AUTHORITY EXPIRES AT 11 59 P M ON JUNE 30 **2018** UNLESS SUSPENDED OR REVOKED IN THE MANNER PROVIDED BY LAW

GIVEN UNDER MY HAND AND SEAL OF OFFICE
THIS DAY JUNE 21 2017

RALPH T HUDGENS
COMMISSIONER OF INSURANCE

LICENSE NUMBER 2008123
NAIC NUMBER 60216

FAILURE TO RETURN THIS PAGE MAY RESULT IN REMOVAL OF YOUR COMPANY FROM COMMODITY LISTING

Buyer Initials DG

IF YOU DESIRE TO SUBMIT A "NO BID" IN RESPONSE TO THIS PACKAGE, PLEASE INDICATE BY CHECKING ONE OR MORE OF THE REASONS LISTED BELOW AND EXPLAIN

___ Do not offer this product or service, remove us from your bidder's list for this item only

___ Specifications too "tight", geared toward one brand or manufacturer only

___ Specifications are unclear

___ Unable to meet specifications

___ Unable to meet bond requirements

___ Unable to meet insurance requirements

___ Our schedule would not permit us to perform

___ Insufficient time to respond

X Other

N/A We have issued a quote

COMPANY NAME Amalgamated Life Insurance Company

AUTHORIZED REPRESENTATIVE _____

SIGNATURE

Gwinnett County Bid for Specific Stop Loss Coverage
GCBOC Invitation to Bid BL119-17
Bid Schedule

FAILURE TO RETURN THIS PAGE AS PART OF YOUR BID DOCUMENT MAY RESULT IN REJECTION OF BID

	Specific Stop Loss Policy Features and Rates	Answer Format	Response
1	**Please confirm you can match the Specific Stop Loss Policy Features as requested under the bid**		
a	**Confirm you are willing to provide a 24/12 contract for Gwinnett's self-insured medical/pharmacy plans with Aetna.**	**text**	Agreed
b	**Confirm you willing to accept Aetna s shared savings fee of 50% as a valid expense.**	**text**	Agreed
c	**Please explain how your organization will work with Aetna to process large claim reibursements within 30 days**		We will implement an Expedited Claims Handling process for Gwinnett. Once we see on the monthly reports that a claim is within $50 000 or over the Spec deductible we will verify eligibility and COB directly with Aetna immediately Once verified we will process the claim within 7 working days Within 7 working days from receipt with all required information such as the following Eligibility – Enrollment for the employee and patient (claimant) Work Status for the Employee (active on FMLA, LOA STD etc.) COB – Including Medicare Eligibility (over age 65 ESRD) Transplant Case Rates Accident Details including Other Party Liability The U-04 for Hospital bills Over $100 00 or Revenue Codes Listed on Claims Pre-authorization Verification We will also put Gwinnett on a Special Handling Process whereby we will take the reimbursements to Gwinnett out of our normal check run cycle and have the claim paid in a special check run so there is no delay in waiting for our normal check run cycle We will guarantee all claims will be paid within 7 working days of receipt or we will return 2% of our monthly premium in the month we did not meet the requirement. Keep in mind that we can also accept reporting more frequently from Aetna that would also expedite this process
d	**Confirm you can provide monthly rates on a composite basis**	**text**	Agreed
	Gwinnett County requires pricing to remain firm for the duration of the initial term of the contract. Failure to hold firm pricing for the initial term of the contract will be sufficient cause for Gwinnett County to declare proposal non responsive.		
e	**$325 000 ISL Deductible Year 1 composite rate Per Employee Per Month**	**dollar**	$44 72
f	**$350 000 ISL Deductible Year 1 composite rate Per Employee Per Month**	**dollar**	$39 94
g	**$375 000 ISL Deductible Year 1 composite rate Per Employee Per Month**	**dollar**	$36 51
	Please provide your best estimate of rate increases below (Note you must complete % estimates and reasons-otherwise the coverage will be marketed for the following year)		
h	**First Renewal Option (Year 2)**	**percentage**	9%
i	**Reason for Year 2 Increase**	**text**	Trend
j	**Second Renewal Option (Year 3)**	**percentage**	9%
k	**Reason for Year 3 Increase**	**text**	Trend
l	**Second Renewal Option (Year 4)**	**percentage**	9%
m	**Reason for Year 4 Increase**	**text**	Trend
n	**Second Renewal Option (Year 5)**	**percentage**	9%
o	**Reason for Year 5 Increase**	**text**	Trend
p	**Confirm you can offer +/ 15% for enrollment differential**	**text**	Agreed
q	**Confirm you can offer +/ 10% for contract size differential**	**text**	Agreed

Gwinnett County Bid for Specific Stop Loss Coverage
GCBOC Invitation to Bid BL119-17
Questionnaire

		GENERAL VENDOR INFORMATION Corporate Headquarters	Answer Format	Response
I	1	Carrier Name	text	Amalgamated Life Insurance Company
	2	Street Address	text	333 Westchester Avenue
	3	City	text	White Plains
	4.	State	text	NY
	5	Zip Code	text	10604
	6	Web Address	text	www amalgamatedlife com
		Contacts	**Answer Format**	**Response**
		Please indicate the primary and secondary contact who will answer questions related to this Bid		
	7	**Primary Contact**		
	a	Name	text	Mike Schaefer
	b	Title	text	Managing Director of Strategic Partnerships
	c	Address	text	P O Box 1476
	d	City	text	Geneva
	e	State	text	FL
	f	Zip	text	32732 1476
	g	Phone Number	text	(914) 539-6347
	h	Fax Number	text	(914) 367 2968
	i	E-mail Address	text	mschaefer@amalgamatedlife com
	8	**Secondary Contact**		
	a	Name	text	John Patrick Hull
	b	Title	text	Assistant Vice President, Underwriting
	c	Address	text	333 Westchester Avenue
	d	City	text	White Plains
	e	State	text	NY
	f	Zip	text	10604
	g	Phone Number	text	(914) 367 5465
	h	Fax Number	text	(914) 367-4115
	i	E-mail Address	text	jhull@amalgamatedlife com
		Vendor Financial Strength/Stability	**Answer Format**	**Response**
	9	For the entity that will be underwriting this coverage, provide your most recent financial ratings or filings and effective dates of the ratings from each of the following agencies.		
		Comment: Indicate whether your organization has received a financial rating for each of the rating agencies listed below by using the drop down box in the response cell to the right of each agency's name Do not respond by providing information about your organization's credit ratings.		
	a	**A.M Best. Financial Rating Status**	text	42nd annual consecutive A rating
		Financial Rating (do not report credit rating)	text	A Excellent
		Financial Rating Modifiers (if applicable)	text	
		Date Rating Effective (if rated If not financially rated leave response cell blank)	date	
	b	**Standard & Poor's Financial Rating Status**	text	N/A
		Financial Rating (do not report credit rating)	text	
		Financial Rating Modifiers (if applicable)	text	
		Date Rating Effective (if rated If not financially rated leave response cell blank)	date	
	c	**Moody's Financial Rating Status**	text	N/A
		Financial Rating (do not report credit rating)	text	
		Date Rating Effective (if rated If not financially rated leave response cell blank)	date	
	d	**Fitch Financial Rating Status**	text	N/A
		Financial Rating (do not report credit rating)	text	
		Date Rating Effective (if rated If not financially rated leave response cell blank)	date	
		Vendor References	**Answer Format**	**Response**
	10	**Please provide three employer references that have your specific stop loss policy The references will preferably be for clients of similar size, industry and complexity as GCBOC**		
	a	**Reference 1**		
		Company	text	St. Louis Painters Welfare Plan
		Contact Person	text	Tom Frazier
		Title	text	Plan Manager
		Phone Number	text	314-656 1078
	b	**Reference 2**		
		Company	text	Teamster Local 723 Health & Welfare Fund
		Contact Person	text	Robin Modzelewski
		Title	text	Fund Administrator
		Phone Number	text	908 688-0723
	c	**Reference 3**		
		Company	text	Teamster Joint Council 83
		Contact Person	text	Mike McCall
		Title	text	Fund Administrator
		Phone Number	text	804 282 7204